

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-035180

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1102

STATE FILE NUMBER

FILED SEP 19 1963

VS 300
Rev. 4/59

1 5117
2 0250
3
4 0
5 1
6
7 0
8 2
9 422.1
10
11
12 2-0
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF J.R. McDaniel, M.D. CERTIFICATION

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Clinton	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Joseph,		c. CITY OR TOWN Lathrop,	
Length of stay in 1b 2 weeks		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Meth. Hosp. & Med. Center		d. STREET ADDRESS (If outside, give location) Rural Route #1	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last LESTER R. MEADOWS		4. DATE OF DEATH Month Day Year September 12, 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1906
9. AGE (last birthday) 63		IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture	
11. BIRTHPLACE (City and state or country) Maitland, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Alonzo Don Meadows		13b. MOTHER'S MAIDEN NAME Hettie Riley	
14. NAME OF HUSBAND OR WIFE Ellnora Meadows		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ellnora Meadows-Lathrop, Missouri	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease with decompensation. INTERVAL BETWEEN ONSET AND DEATH 8 days. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 7/27/63 to 9/12/63 and last saw him alive on 9/12/63		Death occurred at 5:20 PM m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE John R. McDaniel, M.D. (Degree or title)		22b. ADDRESS 902 Edmond St., St. Joseph, Mo.	
22c. DATE SIGNED 9/14/63		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 9-14-1963		23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	
23d. LOCATION (City, town, or county) St. Joseph, Missouri		(State)	
24. FUNERAL DIRECTOR Meierhoffer-Fleeman Inc., St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Sept. 17, 1963	
26. REGISTRAR'S SIGNATURE Mrs. Clark Standell			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

Permit issued 9-13-63

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Raymond W. Foor

Licensed Embalmer No.

5147

P. O. Address

St Joseph Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.